Supreme Court, U.S.
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No. ____

IN THE

SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1993

DONNA TIEMEYER, *et al.*

Petitioners,

v.

COMMUNITY MUT. INS. CO., *et al.*

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

PETITION FOR WRIT IN A CIVIL CASE

MITCHELL B. GOLDBERG
CLAUDIA G. ALLEN
2100 PNC Center
201 E. Fifth Street
Cincinnati, Ohio 45202

PHILIP A. LOGAN
9000 Plainfield Road
Cincinnati, Ohio 45236

Attorneys for Petitioner

53 pp

QUESTION PRESENTED

Whether, after a successful ERISA action to compel an insurer to indemnify the plan beneficiary for medical bills incurred but not yet paid, the prevailing plaintiff is entitled to a presumption in favor of the awarding of attorney fees under 29 U.S.C. § 1132(g)(1).

STATEMENT OF CORPORATE AFFILIATION

Petitioner is not affiliated with any corporation.

TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	iv
QUESTIONS PRESENTED	i
STATEMENT OF CORPORATE AFFILIATION	ii
OPINIONS BELOW	1
JURISDICTIONAL STATEMENT	2
STATUTE INVOLVED	3
STATEMENT OF THE CASE	4
REASONS FOR GRANTING THE WRIT	10
CONCLUSION	31

Table of Authorities

Cases	Page
Alyeska Pipeline Co. v. Wilderness Society, 421 U.S. 240 (1975)	25,26
Armistead v. Vernitron Corp., 944 F. 2d 1287 (6th Cir. 1991)	18,19,25
Bittner v. Sadoff & Rudoy Indus., 728 F. 2d 820 (7th Cir. 1984)	14,16
Chambless v. Masters, Mates & Pilots Pension Plan, 815 F. 2d 869 (2d Cir. 1987)	16
Commissioner v. Bilder, 369 U.S. 499 (1962)	30
Curtiss-Wright Corp. v. General Electric Co., 446 U.S. 1 (1980)	26
Eaves v. Penn, 587 F. 2d 453 (10th Cir. 1978)	11,12,14 17,18,19 25,26,27
Ellison v. Shenango Inc. Pension Bd., 956 F. 2d 1268 (3d Cir. 1992)	19
Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989)	20,22
Gray v. New England Tel Co., 792 F. 2d 251 (1st Cir. 1986)	19
Hensley v. Eckerhart, 461 U.S. 424 (1983)	13,21

Hoskins v. Aetna Life Ins. Co.,
6 Ohio St. 3d 272 (1983) 23

Hummell v. S.E. Rykoff & Co.,
634 F. 2d 446 (9th Cir. 1980) 12

*Iron Workers Local No. 272
v. Bowen*, 624 F. 2d 1255
(5th Cir. 1980) 17,18

*Landro v. Glendenning
Motorways, Inc.*, 625 F. 2d 1344
(8th Cir. 1980) 13

Local 504 v. Roadmaster Corp.,
954 F. 2d 1397 (7th Cir. 1992) 15

*Massachusetts Mutual Life Ins.
Co. v. Russell*, 473 U.S. 134 (1985) 20

*Meridith v. Navistar Int'l Trans.
Corp.*, 935 F. 2d 124 (7th Cir. 1991) 15

Mills v. Electric Auto-Lite Co.,
396 U.S. 375 (1970) 25

Nachwalter v. Christie,
805 F. 2d 956 (11th Cir. 1986) 16

Newman v. Piggy Park Enterprises,
390 U.S. 400 (1968) 13

Pierce v. Underwood, 487 U.S. at 552 15,26

Pilot Life Ins. Co. v. Dedeaux,
481 U.S. 41 (1987) 11,19

*Quesinberry v. Life Ins. Co.
of North America*, 987 F. 2d 1017
(4th Cir. 1993) 16

Rodriguez v. MEBA Pension Trust,
956 F. 2d 468 (4th Cir. 1992) 19

Smith v. CMTA-IAN Pension Trust
746 F. 2d 587 (1984) 12,18

Varhola v. Doe, 820 F. 2d 809
(6th Cir. 1987) 23

Other

Note, *The Need for a Mandatory Award of Attorney's Fees for Prevailing Plaintiffs in ERISA Benefits Cases*, 41 Cath. U.
L. Rev. 871 (1992) 11,21,25

Note, *Attorney's Fees Under ERISA: When is an Award Appropriate?*,
71 Corn. L. Rev. 1037 (1986) 13,25,28

Thomas D. Rowe, Jr.,
The Legal Theory of Attorney
Fee-Shifting: A Critical Overview
1982 Duke L.J. 651 21

Statutes

28 U.S.C. § 1254(1)	2
29 U.S.C. § 1001	2,20
29 U.S.C. § 1001(b)	10,20,22,29
29 U.S.C. § 1132(a)(1)(B)	25
29 U.S.C. § 1132(g)(1)	3,20
29 U.S.C. § 1132(i)	25
29 U.S.C. § 1140	14
29 U.S.C. §§ 1001-1461	10
29 U.S.C. § 1132(g)(1)	10
Civil Rights Attorneys' Fees Awards Act of 1976 42 U.S.C. § 1988	12
Equal Access to Justice Act 28 U.S.C. § 2412(d)(1)(A)	14
Patent Infringement Act 35 U.S.C. § 285	21
Plant Variety Protection Act § 125, 7 U.S.C. § 2565	21
Securities Act of 1933 § 11(e), 15 U.S.C. § 77k(e)	21
Trademark Act § 35, 15 U.S.C. § 1117	21
Trust Indenture Act § 315(e), 15 U.S.C. § 17ooo(e)	21

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OPINIONS BELOW

The opinion of the district court (Pet. App. 1a) is reported at 789 F. Supp. 894 (S.D. Ohio 1992). The opinion of the court of appeals (Pet. App. 22a) has not yet been reported.

JURISDICTIONAL STATEMENT

The decision of the court of appeals was filed on November 3, 1993. The jurisdiction of the court is invoked under 28 U.S.C. § 1254(1). The jurisdiction of the district court was invoked under the Employment Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.*

STATUTE INVOLVED

Section 502(g)(1), 29 U.S.C. § 1132(g)(1), provides, in pertinent part:

> In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

STATEMENT OF THE CASE

Petitioner Donna Tiemeyer was an employee of Respondent Children's Hospital Medical Center ("Children's Hospital"), Cincinnati, Ohio, in October, 1987, when she and her husband made arrangements for the private adoption of unborn male triplets. Mrs. Tiemeyer was covered under the hospital's Major Medical Plan for Regular Full-Time and Part-Time Employees (the "Plan"), for which she paid a portion of the premiums. (Pet. App. 23a) In order to assure coverage for the infants she was about to adopt, she inquired of the benefit department at Children's Hospital about their eligibility, and was referred to the applicable policy provision in the Administrative Manual.[1] (Pet. App. 3a)

On December 29, 1987, the triplets were born. (Pet. App. 23a) They were immediately placed in the critical care unit of University Hospital, being two months premature, severely underweight (ranging from 1 lb. 15

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[1] "[T]he adoption date becomes the effective date of the coverage. The adoption date is the date the child established residence with the subscriber, or the date the petition for adoption is filed, which ever [sic] occurs last." (Pet. App. 3a-4a)

oz. to 2 lbs. 12 oz.), and very ill. (Pet. App. 23a) As late as January 14, 1988, when hospital charges had already surpassed $100,000.00, attorneys for Respondent Community Mutual Insurance Company, the Plan's Administrator, were still "in the process of reviewing Donna Tiemeyer's coverage so that we may properly advise you regarding coverage for the triplets Ms. Tiemeyer is adopting." (Pet. App. 4a)

The Tiemeyers filed an adoption petition on January 15, 1988. (Pet. App. 5a) On the same day they applied to Children's Hospital to add the triplets as dependents under the Plan. (Pet. App. 5a) Four days later, a Plan attorney notified the Tiemeyers that the infants would not be covered. Since the "adoption date" was defined in the Plan as the date the infants "established residence" with the policy holder, and since the infants had not been physically removed from the hospital (they were too ill), it was the attorney's opinion that the residency requirement had not been satisfied. (Pet. App. 24a) Upon being discharged from University Hospital and taking up residence in the Tiemeyers' home,

in March, April, and May of 1988, each of the boys was accepted for coverage under the Plan.

The Tiemeyers appealed the denial of coverage for the period before discharge. During the administrative appeal process, University Hospital filed suit against the Tiemeyers in state court seeking over $289,000.00 in hospital and related medical expenses incurred after the adoption but prior to discharge, plus interest and court costs. (Pet. App. 24a-25a) The total uncovered health care expenses for the Tiemeyer infants was over $413,000.00. The Tiemeyers were unable to pay any part of their hospital bill; they did pay $4,259.00 to their doctors.[2]

After the Plan Administrator denied their final appeal, the Tiemeyers brought this ERISA action against Children's Hospital and CMIC.[3] While relief in the form of a money judgment was requested, it was apparent from

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[2] Subsequent to the decision by the court of appeals, University Hospital bypassed the Tiemeyers and settled directly with the Plan for an undisclosed amount. It then dismissed its state court claim against the Tiemeyers.

[3] The Complaint, later amended to include the Plan as Defendant, also alleged causes of action for breach of contract and violation of civil rights. Both were later dismissed.

the time the non-ERISA claims were dismissed that the only practical form of relief available from Respondents was indemnification for medical bills owed to University Hospital and others for the care of the Tiemeyer infants.

On cross motions for summary judgment, the district court, reviewing the denial of benefits *de novo*, held that "the administrator's decision to deny benefit coverage is an inconsistent and unreasonable interpretation under the Plan." (Pet. App. 16a) It therefore granted the Tiemeyers' motion for summary judgment. (Pet. App. 21a) However, without a factual record upon which to base its finding, it denied their claims for attorney fees, costs, and prejudgment interest. (Pet. App. 19a, 21a)

The court of appeals affirmed on the merits:

> Tiemeyer reasonably believed, pursuant to the Plan's express wording and the reasonable inferences that may be drawn therefrom, that residency would have been established when the boys were placed in her custody and she was responsible for their care . . . . [T]he appellees' claim is wholly unavailing.

(Pet. App. 36a) A concurring opinion termed the Plan Administrator's decision "arbitrary and capricious." (Pet. App. 44a)

The court below also affirmed the district court's denial of attorney fees and costs:

> When exercising its discretion, a trial court should consider the following factors: (1) the degree of the opposing party's culpability or bad faith; (2) the opposing party's ability to satisfy an award of attorney's fees; (3) the deterrent effect of an award on other persons under similar circumstances; (4) whether the party requesting fees sought to confer a common benefit on all participants and beneficiaries of an ERISA plan or resolve significant legal questions regarding ERISA; and (5) the relative merits of the parties' positions.

(Pet. App. 37a) Since the district court had performed a cursory application of these factors, it was held not to have abused its discretion under ERISA's fee-shifting statute, 29 U.S.C. § 1132(g)(1). (Pet. App. 38a-39a)

Finally, as to prejudgment interest, the court of appeals held that "the district court abused its discretion by denying the Tiemeyers' request for prejudgment interest without explanation." It therefore remanded that

issue with instructions that the district court support its determination with factual findings. (Pet. App. 39a-41a)[4]

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[4] The prejudgment interest issue is awaiting hearing at the time of the filing of this petition. Petitioner can ascertain no finding of fact or law available to the district court on remand which would bear in any way upon the attorney fees issue presented in this Petition. *See United States v. General Motors Corp.*, 323 U.S. 373, 377 (1945) (existence of remand order no bar to certiorari review); *see generally* Stern, Gressman & Shapiro, SUPREME COURT PRACTICE (6th Ed. 1986), pp. 224-26.

REASONS FOR GRANTING THE WRIT

A. THE FEDERAL COURTS OF APPEALS ARE SERIOUSLY DIVIDED AS TO THE PROPER INTERPRETATION OF ERISA'S FEE-SHIFTING PROVISION.

The Employee Retirement Income Security Act of 1974 ("ERISA"), codified, as amended, at 29 U.S.C. §§ 1001-1461 and in scattered sections of the Internal Revenue Code, was enacted, by its own terms, to safeguard "interests of participants in employee benefit plans and their beneficiaries by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b) (1982). Section 502(g)(1) of the Act, 29 U.S.C. § 1132(g)(1), authorizes courts to "allow a reasonable attorney's fee and costs of action to either party." The legislative history of the Act furnishes no guidance as to the precise interpretation of this fee-shifting provision.

In 1978, the Tenth Circuit set out a five-factor test intended to govern the exercise of discretion by a district court in allowing or denying a fee request. Briefly, this

test required consideration of (1) bad faith; (2) ability to pay; (3) the deterrent effect of an award; (4) any benefit conferred on members of the plan as a whole; and (5) the relative merits of the parties' positions. *Eaves v. Penn*, 587 F. 2d 453, 465.

Nearly all federal courts of appeals have nominally accepted the *Eaves* test. However, ERISA litigation varies widely in factual background; the language of the test itself leaves much room for interpretation; and some courts have recognized that other factors may also be important. The result has been that the circuits, instead of developing a "federal common law of rights and obligations under ERISA-regulated plans," *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987), have split at least five ways on the crucial question of which party has the burden, and what that burden is, when seeking (or resisting) an award of attorney fees under ERISA.[5]

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[5] A comprehensive study revealing the "strikingly disparate application of the *Eaves* test" is described in Note, THE NEED FOR A MANDATORY AWARD OF ATTORNEY'S FEES FOR PREVAILING PLAINTIFFS IN ERISA BENEFITS CASES, 41 Cath. U.L. Rev. 871, 883-84 (1992).

1. Presumption in Favor of Fee Award: Eighth and Ninth Circuits.

In *Smith v. CMTA-IAN Pension Trust*, 746 F. 2d 587 (1984), the Ninth Circuit considered a claim for pension benefits which was eventually settled with the stipulation that the claimant could still petition for attorney fees. The district court used the five-factor test set out in *Hummell v. S.E. Rykoff & Co.*, 634 F. 2d 446, 453 (9th Cir. 1980), which adopted the *Eaves* factors. In doing so it placed the burden upon the plaintiff to show his entitlement to fees, negating any presumption that attorney fees should be granted unless the *losing* party demonstrates otherwise.

The Ninth Circuit reversed. Its rationale was based upon the remedial policy underlying ERISA, as well as on the analogy provided by the discretionary attorney fees provision of the Civil Rights Attorneys' Fees Awards Act of 1976, 42 U.S.C. § 1988. Its holding stated the fee award presumption as follows:

> As a general rule, ERISA employee plaintiffs should be entitled to a reasonable attorneys' fee "if they succeed on any significant issue in litigation which achieves

> some of the benefit the parties sought in bringing suit." *Hensley v. Eckerhart*, 461 U.S. at 433 . . . .

746 F. 2d at 589.

Similarly, *Landro v. Glendenning Motorways, Inc.*, 625 F. 2d 1344 (8th Cir. 1980), considered a request for attorney fees following success on the merits by a plaintiff who was also seeking past pension benefits. Applying the same broad view of the purpose of ERISA, as well as the civil rights analogy, the Eighth Circuit held that a prevailing plaintiff "should ordinarily recover an attorney's fee unless special circumstances would render such an award unjust," citing *Newman v. Piggy Park Enterprises*, 390 U.S. 400, 402 (1968). 625 F. 2d at 1356. The court noted that "the mere absence of bad faith on the part of the losing defendant is not such a 'special circumstance' as to negate the presumption that an award for attorney's fees should be granted to the prevailing plaintiff."[6]

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[6] With respect to prevailing defendants, and non- or partially prevailing plaintiffs, further complexities arise which are not pertinent here. *See generally* Note, *Attorney's Fees Under ERISA: When is an Award Appropriate?*, 71 CORN. L. REV. 1037, 1045-48 (1986).

2. The "Modest Presumption" in the Seventh Circuit.

The Seventh Circuit has adopted a different interpretation of *Eaves*. *Bittner v. Sadoff & Rudoy Indus.*, 728 F. 2d 820 (1984), involved a prevailing *defendant* who was awarded attorney fees after successfully defending an ERISA retaliatory discharge action under 29 U.S.C. § 1140. The Seventh Circuit refused to adopt a blanket presumption in favor of such an award. *Id.* at 829. However, finding an analogy in the Equal Access to Justice Act, 28 U.S.C. § 2412(d)(1)(A), it held that a prevailing party was entitled to a "modest presumption" in favor of the granting of attorney fees, which should be ordered unless it is found that the legal position of the losing party was "substantially justified or that special circumstances make an award unjust." *Id.* at 830. The term "substantially justified" was defined as being "more than merely not frivolous, but less than meritorious." *Id.* The award to the prevailing defendant was vacated and the case remanded for application of the new test.

The Seventh Circuit later paraphrased the test in terms of whether "the losing party's position [was] substantially justified and taken in good faith, or was that party simply out to harass its opponent?" *Meridith v. Navistar Int'l Trans. Corp.*, 935 F. 2d 124, 128 (7th Cir. 1991), reaffirmed in *Local 504 v. Roadmaster Corp.*, 954 F. 2d 1397, 1405 (7th Cir. 1992).[7] Naturally, proving that a losing party was "simply out to harass its opponent" would be difficult, especially for prevailing plaintiffs seeking benefits from large health insurers or pension trusts. On the other hand, in *Local 504*, *supra*, the Seventh Circuit *reversed* the district court's refusal to award attorney fees, even though the lower court had found that "defendants offered a plausible explanation for their actions which struck the court as having some merit." 954 F. 2d at 1405. Indeed, the court of appeals did not even remand the case for further explanation, but simply declared the defendant's reading of a Congressional statute "not substantially justified." *Id.* at

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[7] This Court used different language - "justified to a degree that could satisfy a reasonable person" - in a case interpreting the fee-shifting provision of the EAJA itself. *Pierce v. Underwood*, 487 U.S. 552, 565 (1988).

1405-06. Under this interpretation of *Bittner*, a presumption in favor of awarding attorney fees to either prevailing party seems much stronger than the "modest presumption" declared in *Bittner* itself.

3. Application of Eaves Test In Light of ERISA's Remedial Purpose: Second, Fourth and Eleventh Circuits.

These three circuits apply the five-factor test without a presumption. However, they require district courts to interpret the test liberally in light of ERISA's remedial purpose. *See, e.g., Chambless v. Masters, Mates & Pilots Pension Plan*, 815 F. 2d 869, 872 (2d Cir. 1987) (fee provisions must be liberally construed, "even when small amounts are involved" - denial of fees reversed); *Quesinberry v. Life Ins. Co. of North America*, 987 F. 2d 1017, 1030 (4th Cir. 1993) (directing the district court to "also consider the remedial purposes of ERISA in making its determination regarding attorneys' fees"); *Nachwalter v. Christie*, 805 F. 2d 956, 962 (11th Cir. 1986) (applying five-factors test but denying fees to a prevailing defendant

while bearing in mind "ERISA's essential remedial purpose").

In none of these decisions were district courts urged to presume either in favor of or against the award of attorney fees. It is arguable, however, that strict adherence to ERISA policy considerations (set out in more detail below) would require district courts in these circuits to begin with at least some presumption that a prevailing plaintiff should receive such an award.[8]

4. Eaves Test Plus Other Considerations: Fifth and Sixth Circuits.

To add to the confusion, the Fifth Circuit permits attorney fees awards to be based upon factors other than those set forth in *Eaves*. In *Iron Workers Local No. 272 v. Bowen*, 624 F. 2d 1255 (1980), the court accepted the five-

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[8] For example, under the rule in *Quesinberry*, *supra*, would a district court, denying any presumption of fees but considering "the remedial purposes of ERISA in making its determination," 987 F. 2d at 1030, be acting within its discretion if it denied fees to a health benefits claimant who, as in the instant case, was seeking only indemnification, where the five factors were inconclusive? Our argument, *infra*, that a claimant seeking indemnification would be unable to obtain counsel on a contingent fee basis, which fact could foreclose an ERISA action, might persuade a district court in the Fourth Circuit that it must award fees or abuse its discretion.

factor *Eaves* test while stating that "in particular types of cases, or in any individual case, however, other considerations may be relevant as well." Such a rule appears to allow district courts in the Fifth Circuit more freedom than elsewhere to apply their own unspecified criteria in addition to the *Eaves* factors.

Likewise, in *Armistead v. Vernitron Corp.*, 944 F. 2d 1287, 1302-03 (6th Cir. 1991), the court, while declining to accept an overall presumption, stated that it could "clearly envisage circumstances where fee-shifting would be proper" on the ground that plaintiffs would be unable to secure competent attorneys without it. *Id.* at 1305. It went on to state that this matter "would have to be determined case by case." *Id.* Finally, it recognized "the need for further evolution of the law of fee-shifting under ERISA," *id.* at 1304, citing the Fifth Circuit decision in *Iron Workers*, *supra*, as an example.

5. Eaves Test Only: First and Third Circuits.

On the other end of the presumption continuum, two circuits have expressly declined to follow the Ninth Circuit presumption in *Smith*, *supra*, while embracing the

five-factor test as wholly adequate. *Ellison v. Shenango Inc. Pension Bd.*, 956 F. 2d 1268, 1274 (3d Cir. 1992) (employee action to recover pension benefits); *Gray v. New England Tel Co.*, 792 F. 2d 251, 258-59 (1st Cir. 1986) (action involving notice of ERISA benefits and other claims).

Thus, far from establishing a uniform federal common law of fee-shifting, *see Pilot Life*, *supra*, the courts of appeals have reached widely disparate conclusions in attempting to instruct district courts as to the exercise of their discretion under Section 502(g)(1). Individual panels have even disagreed on how to categorize precedents from other circuits. *See Ellison*, *supra*, 956 F. 2d at 1274 n. 7; *Rodriguez v. MEBA Pension Trust*, 956 F. 2d 468, 477 n. 3 (4th Cir. 1992). ERISA claimants do not have the luxury of forum shopping for favorable attorney fees jurisdictions. Where the *Eaves* test is applied by rote, the chances of a prevailing plaintiff obtaining an award are weak. The Sixth Circuit has expressly pointed out "the need for further evolution of the law of fee-shifting under ERISA . . . ." *Armistead*,

supra, 944 F. 2d at 1304. In these circumstances, guidance from this Court is imperative.

B. BOTH THE GENERAL POLICY CONSIDERATIONS UNDERLYING THE PASSAGE OF ERISA, AND THE LIKELY POLICY BEHIND THE FEE-SHIFTING PROVISION, ARE CONTRAVENED WHEN THE BURDEN IS PLACED UPON PREVAILING PLAINTIFFS TO DEMONSTRATE ENTITLEMENT TO ATTORNEY FEES UNDER THE EAVES TEST.

> ERISA was enacted "to promote the interests of employees and their beneficiaries in employee benefit plans," *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90, 103 S. Ct. 2890, 2896, 77 L.Ed.2d 490 (1983), and "to protect contractually defined benefits," *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S., at 148, 105 S. Ct., at 3093. *See generally* 29 U.S.C. § 1001 (setting forth congressional findings and declarations of policy regarding ERISA).

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 113 (1989). While there is no legislative history concerning the precise application of the fee-shifting provision, 29 U.S.C. § 1132(g)(1), Congress expressly declared in the statute itself that one purpose of the Act was to provide "ready access to the Federal courts." 29 U.S.C. § 1001(b). Most likely a fee-shifting provision was included in ERISA to equalize the strengths of the parties and to provide plaintiffs of modest means, such as the

Tiemeyers, with sufficient incentive to enforce their rights under the statute. *See* Note, *supra* p. 11, n. 5, 41 Cath. U.L. Rev. at 875; *see also Thomas D. Rowe, Jr., The Legal Theory of Attorney Fee-Shifting: A Critical Overview*, 1982 Duke L.J. 651, 664, 666; *compare Hensley v. Eckerhart*, 461 U.S. 424, 430 (1983) (Civil Rights Attorney's Fees Awards Act properly "resulted in fees which are adequate to attract competent counsel, but which do not produce windfalls to attorneys.").

If Congress had intended Section 502(g)(1) to be used in the exceptional case only, it would have said so, as it has on other occasions. *See* Plant Variety Protection Act § 125, 7 U.S.C. § 2565 ("exceptional cases"); Trademark Act, § 35, 15 U.S.C. § 1117 (same, for prevailing parties only); Patent Infringement Act, 35 U.S.C. § 285 (same); Securities Act of 1933 § 11(e), 15 U.S.C. § 77k(e) (allowing for fees to prevailing party "if the court believes the suit or the defense to have been without merit"); Trust Indenture Act § 315(e), 15 U.S.C. § 17ooo(e) (allowing award of fees "having due regard to

the merits and good faith of the claims or defenses made by such party litigant").

The phrase "ready access to the Federal courts," 29 U.S.C. § 1001(b), cannot be considered merely to describe the process of paying a fee and filing a complaint. Congress had to have been aware of the vast disparity between most claimants of health and pension benefits and the insurers and plan administrators who would be deciding when and whether to pay out those benefits. ERISA litigation is usually long, complex and expensive. Subsequent to this Court's decision in *Bruch*, *supra*, health plans have been routinely amended to insert as much discretionary language as possible, thereby limiting *de novo* review in the district court and substituting an abuse of discretion standard. Many ERISA claims are small or, as here, involve only indemnification, or both. Where hundreds of hours of attorney time are required to take a claim through administrative appeals, district court review, and, often,

appellate review, it is the rare claimant who can afford to hire an attorney on an hourly basis.[9]

Contingent fee arrangements are of little use in many of these situations. ERISA damages are generally contractual in nature. However, unlike a plaintiff in a commercial contract case, a simple ERISA claimant cannot recover consequential damages, such as for the "benefit of the bargain" which has been lost. Because insurance companies in ERISA actions face little or no risk, they are willing to place extraordinary hurdles in the way of one-time claimants seeking to obtain benefits which should simply have been paid in the first place.[10] In addition, where the claimant must pay over his or her entire recovery to a provider of health services, there is no fund with which to pay the successful attorney at all. "Ready access to the Federal courts" can only be

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[9] Attorneys for the Tiemeyers have expended some 700 hours so far, even though no evidentiary hearing has taken place. They have also advanced over $4,000.00 in costs.

[10] If an ordinary insurance company attempted this, it might become liable for a bad-faith tort recovery, including punitive damages, under state law. *E.g., Hoskins v. Aetna Life Ins. Co.*, 6 Ohio St. 3d 272, 452 N.E. 2d 1315 (1983). Punitive damages have not been allowed under ERISA. *See Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985); *Varhola v. Doe*, 820 F. 2d 809, 817 (6th Cir. 1987).

accomplished by applying ERISA's fee-shifting provision in a manner which will solve these practical problems.[11]

As has been recognized both by courts and commentators, the *Eaves* five-factor test bears little, if any, relationship to the policy behind ERISA. *Armistead v. Vernitron Corp.*, *supra*, 944 F. 2d at 1303 (6th Cir. 1991); Note, *supra* p. 11, n. 5, 41 Cath. U. L. Rev. at 884 (1992); Note, *supra* p. 13, note 6, 71 CORN. L. REV. at 1058-61. The first factor, "bad faith by losing party," and the fourth factor, "the amount of benefit conferred on members of the . . . Plan as a whole," each codifies a well established common law fee-shifting doctrine. *See, e.g., Alyeska Pipeline Co. v. Wilderness Society*, 421 U.S. 240, 258-59 (1975); *Mills v. Electric Auto-Lite Co.*, 396 U.S. 375, 396-

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[11] In the instant case there is a nominal contingent fee agreement requiring Petitioners to pay their attorneys a percentage of the amount saved through the attorneys' efforts. Since University Hospital has now settled with the Plan, behind the back of Petitioners, for an undisclosed amount, virtually everything once owed by Petitioners has now been "saved." Therefore, Petitioners are obligated to their counsel for over $100,000.00, an amount far beyond their ability to pay. It is doubtful whether any attorney seeing this result would take on a case of this sort, since, where the suitability of attorneys fees is determined only by mechanical application of the *Eaves* factors, attorneys will remain uncompensated even though (as here) every judge involved has agreed that the Plan should have provided coverage from the date of the petition for adoption.

97 (1970). If these were primary concerns, the ERISA fee-shifting provision would be largely superfluous.

The second *Eaves* factor, the ability of the losing party to pay attorney fees, refers to the problems which arise where pension fund assets are depleted, thus harming plan beneficiaries. *See* Note, *supra* p. 13, n. 6, 71 Cornell L. Rev. at 1059. Not only is this factor not present in cases, such as the instant one, where health insurance is involved, but the policy behind ERISA is not furthered by consideration of where the deep pocket lies.

The third factor (deterrent value) has little connection to fee-shifting, statutory or otherwise. Compensatory damages, along with the necessity that the losing party pay its own costs, have always been considered sufficient to deter repeat conduct under the American rule. ERISA already allows for compensatory damage awards, 29 U.S.C. § 1132(a)(1)(B), and civil penalties are possible under 29 U.S.C. § 1132(i). It is unlikely that there was any punitive intent embedded in the ERISA fee-shifting provision, especially since bad faith, the usual impetus for punitive fee-shifting, is

sufficient to bring about an award of attorney fees absent any statutory provision whatever. *See Alyeska, supra.*

Finally, the fifth factor (relative merits of the parties' positions) again has no relationship to any policy underlying the act. In addition, where a losing defendant's legal argument is so weak as to indicate that attorney fees should be granted under *Eaves*, the situation would tend also to be covered under the common law bad faith doctrine noted above.

This Court has expressed its reluctance "either to fix or sanction narrow guidelines for the district courts to follow" in deciding whether to award attorney fees. *Pierce v. Underwood, supra*, 487 U.S. at 562, quoting *Curtiss-Wright Corp. v. General Electric Co.*, 446 U.S. 1, 10-11 (1980). In view of the inappropriateness of the *Eaves* factors, as well as the extreme divergence in their application, we submit that the time has come for harmonizing ERISA's fee-shifting provision with the underlying policy of the Act, as well as supplying a uniform guide for plaintiffs and their counsel in all jurisdictions.

In doing so, this Court should take note of the vast difference among plan beneficiaries as litigants, depending upon whether they are (1) wealthy enough to hire counsel on an hourly basis whatever the claim; (2) seeking an actual monetary recovery, generally pension benefits, which is large enough to induce an experienced attorney to represent the claimant on a contingent-fee basis; (3) seeking only reimbursement of out-of-pocket expenses, typically medical, in a large enough amount so that a contingent fee is feasible, even if the plaintiff thereby sacrifices full compensation; or (4) requesting indemnification or equitable relief so that, without an award of attorney fees, no representation is likely.

These considerations seem far more relevant to the interpretation of a congressionally mandated discretionary fee-shifting provision than do any of the *Eaves* factors. They can even be boiled down into a single question: *Would a given action have been brought at all absent a strong probability of obtaining attorney fees if the claim should prevail?* Petitioner submits that the only way to vindicate the congressional policy involved here, both

the general policy underlying the Act itself and the specific mandate for shifting attorney fees, is by enforcing a presumption in favor of the award of attorney fees to prevailing plaintiffs, *at the very least* in circumstances where the action would not have been brought absent such a presumption. *See* Note, *supra* p. 13, n. 6, 71 Corn. L. Rev. at 1051.

The case described in this Petition is not unusual. The need for medical care awaits neither administrative appeals nor legal determinations. Extraordinary bills can be run up while the Plan Administrator is still contemplating whether to cover them or not. Even moderate hospitalization soon exhausts the assets of all but the wealthiest claimants. Health benefits claims often involve complex medical determinations, such as whether a given treatment was "medically necessary." Such determinations are often based upon a large body of historical facts. In the instant case, the issue on the merits before the district court was one of plan interpretation only, essentially a legal question based

upon facts which were largely undisputed.[12] Nevertheless, the four-volume Joint Appendix in the court of appeals numbered 884 pages. Any practical view of this action will demonstrate that it holds no hope of *any* recompense to the attorneys without an award of fees. The righting of a moral wrong is arguably pay enough; however, it is the rare attorney who can be expected to take on an insurance company over a complex ERISA claim without a reasonable expectation of compensation should he or she succeed. Therefore, the explicit principle of "ready access to the Federal courts," set out by Congress in the Act itself, 29 U.S.C. § 1001(b), cannot be furthered without a new look at ERISA's fee-shifting provision.

Naturally, Petitioners would argue on the merits for a presumption that attorney fees should be granted to a prevailing plaintiff absent unusual circumstances. However, regardless of which interpretation of Section 502(g)(1) is correct, it is apparent that there is an urgent "need for a uniform rule on the point," *Commissioner v.*

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[12] It was decided on cross-motions for summary judgment. (Pet. App. 1a)

Bilder, 369 U.S. 499, 501 (1962), or, in any event, for guidance relating to the practical issue of dealing with claims which would not be brought absent a reasonable probability of compensation for the successful attorneys. This Court should therefore grant the Petition for Certiorari.

CONCLUSION

For the foregoing reasons, Petitioners respectfully request this Court to issue a writ of certiorari to the United States Court of Appeals for the Sixth Circuit.

Respectfully submitted,

Mitchell B. Goldberg
Claudia G. Allen
STRAUSS & TROY
2100 PNC Center
201 East Fifth Street
Cincinnati, Ohio 45202-4186
(513) 621-2120

Philip A. Logan
KATZMAN, LOGAN & HALPER
9000 Plainfield Rd.
Cincinnati, Ohio 45236

ATTORNEYS FOR PETITIONERS

Of Counsel:

Stephen R. Felson
36 E. Seventh St., #1600
Cincinnati, Ohio 45202

IN THE UNITED STATES DISTRICT COURT
OF THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

Donna Tiemeyer,
et al.

Plaintiffs,

Filed
Kenneth J Murphy
APR 16 306pm '92

v.

C-1-90-509

Community Mutual Insurance
Company, *et al.*,

Defendants.

ORDER

This matter is before the Court upon cross-motions for summary judgment (documents 36, 37 and 38). Fed. R. Civ. P. 56(c). The Plaintiffs assert a claim under the Employee Retirement Income Security Act of 1974 (ERISA) to recover benefits allegedly due to them as participants in an employee welfare benefit plan, 29 U.S.C. § 1132(a)(1)(B), and for an alleged breach of fiduciary duty, 29 U.S.C. § 1132(a)(2). In accordance with Federal Rule of Civil Procedure 52, this Court herewith submits its Findings of Fact, Opinion and Conclusions of Law.

FINDINGS OF FACT

[1] Donna Tiemeyer (Tiemeyer), and employee of the Children's Hospital Medical Center (CHMC), and her husband Thomas Tiemeyer were provided family coverage through CHMC under the a group policy - the CHMC Blue Cross Blue Shield and Major Medical Plan for Regular Full-Time and part-Time Employees (Plan)¢ The Plan was purchased from the Community Mutual Insurance Company (Community Mutual or CMIC). CHMC administered the Plan. Community Mutual was responsible for enrollment administration and the day-to-day claims. Stipulated Statement of Facts, at 2, ¶¶ 6, 7 and 9, document 39.

[2] On October 13, 1987, a co-worker informed Tiemeyer of a pregnant young woman who wanted to give her expected triplets up for adoption. Interested in the possibility of adopting the triplets, Tiemeyer consulted the Summary Plan Description booklet (SPD or "book") issued to the Plan's participants. Deposition of Donna Tiemeyer, at 32-33; Stipulated Statement of Facts, at 3 ¶¶ 11-12, document 39. Under the heading ELIGIBILITY

INFORMATION - Who is Eligible the SPD states that "[e]ligible children are your [a Plan participant's] unmarried children who have not reached the age of 19." Stipulated Statement of Facts, Exhibit 3 at 4, document 39. (clarification added).

[3] Also on October 13, 1987, Tiemeyer contacted CHMC benefits specialist Mary Gavin regarding coverage for the triplets. Deposition of Donna Tiemeyer, at 12, 18, 32-33; Stipulated Statement of Facts, at 3, ¶¶ 11-12, document 39. Gavin informed Tiemeyer of Community Mutual's policy regarding coverage of an adopted child. Gavin told Tiemeyer that she would check to see if this policy had changed and get back to her. Before the triplets were born Gavin called Tiemeyer and read to her the applicable policy from the Administrative Manual. Deposition of Donna Tiemeyer, at 70-72; Deposition of Mary K. Gavin, at 91-97. That policy provides:

> What to do when an employee adds a dependent
>
> In the case of child adoption, if the application is received within 30 days of the adoption, the adoption date becomes the

> effective date of the coverage. The adoption date is the date the child established residence with the subscriber or the date the petition for adoption is filed, which ever occurs last.

Stipulated Statement of Facts, Exhibit 5 at 14, document 29.

[4] On December 29, 1987, the unidentified young woman gave birth to triplets at the University of Cincinnati Hospital. The infants incurred serious medical problems associated with their premature birth and were placed in the Hospital's critical care unit. Stipulated Statement of Facts, at 3 ¶ 13, document 39; Plaintiffs' Motion for Summary Judgment, Exhibit I, document 36.

[5] During this time period David A. Garretson, an attorney handling the private adoption for the Tiemeyers, discussed the situation with Community Mutual attorneys Amy Zeldin and Ray Umstead. In a January 14, 1988, letter Zeldin informed Garretson that "we are in the process of reviewing Donna Tiemeyer's coverage so that we may properly advise you regarding coverage for the triplets Ms. Tiemeyer is adopting." Stipulated Statement of Facts, Exhibit 7, document 39.

[6] On January 15, 1988, the Tiemeyer's filed a petition in the Hamilton County Court of Common Pleas, Probate Division, for the adoption of Joshua William Tiemeyer, Zachary Gene Tiemeyer, and Geoffrey Robert Tiemeyer. The Probate Division issued an Interlocutory Order of Adoption on April 11, 1988, and a granted a Final Decree of Adoption on November 3, 1988. Plaintiffs' Motion for Summary Judgment, Exhibit B, document 36; Stipulated Statement of Facts, Exhibit 6, document 39.

[7] Hours after filing the adoption petition Tiemeyer filed an application with CHMC to add the triplets as her dependants under the Plan. The effective date to add the triplets is recorded as "1/15/88*." The asterisk was notated by Tiemeyer at Gavin's request to indicate "or as soon as poss [possible] legal date." Stipulated Statement of Facts, Exhibit 4, document 39. (clarification added).

[9] Zeldin "formally and explicitly advised" the Tiemeyers in a January 19, 1988, letter to Garretson that the triplets were not covered under the Plan because they

failed to satisfy the adoption date residency requirement. This letter was also sent to Gavin. CHMC's Motion for Summary Judgment, at 4, document 38; Community Mutual's Motion for Summary Judgment, at 9, document 37; Stipulated Statement of Facts, Exhibit 7, document 39.

[10] The Tiemeyer's appealed the coverage denial to the Community Mutual Corporate Appeals Committee. The Committee denied the appeal. Corresponding to the hospital discharge date of each Tiemeyer infant the Committee stated that "Jeffery [sic] established his residency in the Tiemeyer household on March 2, 1988; Joshua on April 23, 1988; and Zachary on May 13, 1988. Therefore, these are the dates on which the criteria for coverage of adoptive children were satisfied." Stipulated Statement of Facts, Exhibits 8 and 9, document 39.

[11] The Tiemeyers instituted this action on June 6, 1990. Complaint, at 1, document 1. The Plaintiffs claim that the health care expenses incurred by the Tiemeyer infants total $413,470.00. First Amended

Complaint, at ¶ 14 and Exhibit C, document 13; Stipulated Statement of Facts, Exhibit J, document 39.

OPINION

Summary Judgment

The summary judgment procedure under Federal Rule of Civil Procedure 56 is designed to secure a just, speedy, and inexpensive determination of any action. Celotex Corp. v. Catrett, 477 U.S. 317, 327 (1986). Rule 56(c) permits the Court to grant summary judgment as a matter of law only after the moving party has identified as the basis of its motion "the pleadings, depositions, answers to interrogatories, and admission on file, together with the affidavits, if any" which demonstrate the absence of any genuine issue of material fact. Celotex, 477 U.S. at 323.

A party opposing a properly supported motion for summary judgment "may not rest upon mere allegations or denials of his pleading, but . . . must set forth specific facts showing that there is a genuine issue for trial." Anderson v. Liberty Lobby, 477 U.S. 242, 248 (1986) quoting, First National Bank of Arizona v. Cities Service

Co., 391 U.S. 253 (1968). The evidence of the nonmovant is to be believed and all justifiable inferences are to be drawn in his favor. Anderson, supra at 255 citing, Adikes v. S. H. Kress & Co., 398 U.S. 144, 158 (1970). The function of the Court is not to weigh the evidence and determine the truth of the matter but to determine whether there is a genuine issue for trial. Anderson, supra at 249. There is no genuine issue for trial unless there is sufficient evidence favoring the nonmoving party for a jury to return a verdict for that party. Anderson at 249 citing Cities Service, 391 U.S. at 288-289. If the evidence is merely colorable, Dombrowski v. Eastland, 398 U.S. 89 (1967) or is not significantly probative, Cities Service, supra at 290, summary judgment may be granted. Anderson, supra at 249-50.

The Standard of Review and Application of Trust Law Principles

Under ERISA, 29 U.S.C. § 1132(a)(1)(B), a plan administrator's benefit determination is "reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to

determine eligibility for benefits or to construe the terms of the plan." Firestone Tire and Rubber Co., v. Bruch, 489 U.S. 101, 115 (1989). Where the administrator or fiduciary has a clear grant of discretionary authority an arbitrary and capricious standard of review applies. Firestone, 489 U.S. at 115; Anderson v. Great West Life Assur. Co., 942 F. 2d 392, 394 (6th Cir. 1991); Brown v. AMPCO-Pittsburgh Corp., 876 F. 2d 546, 550 (6th Cir. 1989).

When interpreting the language of an ERISA plan the courts are guided by the principles of trust law. Firestone, 489 U.S. at 110; Wells v. U.S. Steel & Carnegie Pension Fund, Inc., 950 F. 2d 1244, 1248 (6th Cir. 1991); Great West, 942 F. 2d 92, 395 (6th Cir. 1991). "As they do with contractual provisions, courts construe terms in trust agreements without deferring to either party's interpretation." Firestone, 489 U.S. at 112; Great West, 942 F. 2d at 395. When a plan gives a trustee the "power to construe disputed or doubtful terms" the trustee's interpretation, if reasonable, will not be disturbed." Firestone, 489 U.S. at 111; Wells, 950 F. 2d at 1248.

The Defendants contend that Community Mutual possesses a grant of discretionary authority because a provision on the "inside cover of the SPD . . . gives the plan the right and obligation to approve applicants for participation." Motion of Defendant Community Mutual Insurance Company for Summary Judgment, at 14, document 37; Motion by Defendants CHMC and the Plan for Summary Judgment, at 7, document 38. The inside cover provision states:

> Subject to the payment of fees, all persons who have:
>
> * satisfied the eligibility conditions,
> * applied for coverage, and
> * have been approved by the Plan,
>
> are covered by the group contract. Such persons are called **covered persons** (or you, your).

Stipulated Statement of Facts, Exhibit 3, document 39.

The Defendants also contend that the following SPD booklet provision reserves discretion "to allow the Administrator to make determinations concerning coverage:"

HOSPITALIZATION BENEFITS

* * * *

What is not covered

We are unable to cover some types of care. The decision about noncovered care will be made by us based on medical information supplied by physicians, facilities, or a medical foundation or utilization review committee.

Memorandum of CHMC and the Plan in Opposition to Plaintiffs Motion for Summary Judgment, at 15, document 43. Stipulated Statement of Facts, Exhibit 3 at 8, document 39.

The inside cover provision assigns the task of approval, and it lists four requirements which must be fulfilled in order for a person to be covered by the group contract. The latter SPD booklet provision grants discretion only as to what types of hospital care or treatment are covered. Neither provision grants Community Mutual or CHMC discretionary authority to determine benefit eligibility or to construe the terms of the Plan. Great West, 942 F. 2d at 395 ("[D]iscretion is not an all-or-nothing proposition. A plan can give an administrator discretion with respect to some decisions, but not others."). The absence of a clear grant of discretion dictates that a de novo standard of review

applies. Brown v. AMPCO-Pittsburgh Corp., 876 F. 2d 546, 550 (6th Cir. 1989); Perry v. Simplicity Engineering, 900 F. 2d 963, 965 (6th Cir. 1991).

The Administrator's Decision

In the ERISA context, "[w]hen a court reviews a decision de novo it simply decides whether or not it agrees with the decision under review" as based on the record before the administrator. Simplicity Engineering, 900 F. 2d at 966-67. Community Mutual's decision to deny benefits is based upon the Tiemeyer infants' inability to satisfy an adoption date residency requirement. This requirement consists of a dependent status and a physical presence in the Tiemeyer home:

> Inasmuch as all three children have been inpatients at Children's since birth and are not primarily dependent upon her for support, it is impossible for them to have established residence with Ms. Tiemeyer prior to the date Ms. Tiemeyer's Petition for Adoption was filed, and such impossibility will continue for as long as the children remain hospitalized.

Stipulated Statement of Facts, Exhibit 7, Zeldin's January 19, 1988 letter at 1, document 39. The Community Mutual Appeals Committee upheld this denial on the

same ground. Stipulated Statement of Facts, Exhibit 9, document 39. Upon a review of the record before the administrator this Court disagrees with the decision to deny benefit coverage.

On January 15, 1988, the natural mother consented to give the triplets up for adoption and the Tiemeyer's filed the Petition for Adoption. Stipulated Statement of Facts, Exhibit 6, document 39. On this date, in accordance with the Ohio Revised Code, the Tiemeyers assumed the responsibility for paying the physician and hospital expenses incurred in connection with the birth of the triplets, physician expenses incurred in connection with prenatal care of confinement, and agency expenses incurred in connection with the adoption. O.R.C. § 5103.16, § 3107.10; Stipulated Statement of Facts, Exhibit 6, document 39. As of January 15, 1988, the triplets were primarily, if not totally, dependent upon the Tiemeyer's for support.

Under the Plan a participant's unmarried dependent child between 19 and 25 years old, unmarried dependent child who is a full-time student, or dependent

disabled child may gain coverage by satisfying a residency requirement. Stipulated Statement of Facts, Exhibit 3 at 15, 17, document 39. In each of these situation residency is not interpreted as requiring a physical presence in the Plan participant's home.[1] The Defendants contend that this interpretation is justified because there is "a valid distinction to be made in that at one time [these classes of dependent children] actually lived at the subscribers' home prior to leaving." Memorandum of Defendants CHMC and the Plan in Opposition to Plaintiffs' Motion for Summary Judgment at 12-13, document 43. (clarification added). CHMC benefits specialist Gavin, however, contradicts this contention.[2] Additionally, upon approaching the limiting age of the Plan a dependent child in one of these classes must apply for continuous

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[1] Deposition of Mary K. Gavin at 67-69, 73-74 (disabled child, unmarried dependent child between the ages of 19 and 25 or full-time student may reside outside the Plan participant's home and be covered).

[2] Q. Okay. So a natural born child who is retarded and needs permanent institutionalization, never ever gets to reside with their parents in their parents' house, would still be covered?

****

A. If the institutionalization is confirmed to be medically necessary.

Deposition of Mary K. Gavin at 74.

coverage, it is not automatically granted. Continuing coverage may be granted in the absence of the dependent child's physical presence in the participant's home. Stipulated Statement of Facts, Exhibit 5 at 15, 17, document 39; Deposition of Mary K. Gavin, at 67-74.

The Defendants' contention that the triplets established residency on their respective hospital discharge dates also conflicts with Ohio law. The Ohio Revised Code provides, in pertinent part:

> **3107.13 Residence in adoptive home**[3]
>
> A final decree of adoption shall not be issued and an interlocutory order of adoption does not become final, until the person to be adopted has lived in the adoptive home for at least six months after placement by an agency, or for at least six months after the department of human services or the court has been informed of the placement of the person with the petitioner . . . .

O.R.C. § 3107.13

On January 15, 1988, the triplets were placed in the Tiemeyer's home and the Probate Division was informed of the placement. Stipulated Statement of

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[3] Section 3107.13 was retitled as "Probationary period" after the Tiemeyer final adoption decree was issued.

Facts, Exhibit 6, document 39. Geoffrey, Joshua, and Zachary were discharged from University Hospital on march 2, 1988, April 23, 1988, and May 13, 1988, respectively. Stipulated Statement of Facts, Exhibits 8, document 39. In order to issue the November 3, 1988, Final Decree of Adoption as to all of the triplets the Probate Division considered January 15, 1988, as the date residency was established. If the Probate Division had construed the discharge dates as establishing residency then Zachary could not have "lived in the adoptive home for at least six months" in accordance with § 3107.13. The Tiemeyer triplets established residency on January 15, 1988.

The administrator's decision to deny benefit coverage is an inconsistent and unreasonable interpretation under the Plan.[4] Upon review of the

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[4] Community Mutual's "pseudo-adoption" argument poses an unreasonably broad basis for the physical residency requirement. Community Mutual Insurance Company's Memorandum in Opposition to Plaintiffs' Motion for Summary Judgment, at 7, document 40. In contrast to the actual adoption in this case, Zeldin's January 19, 1988 letter evidences that Community Mutual would be intolerant of such "pseudo-adoptions" to gain coverage. Stipulated Statement of Facts, Exhibit 7 at 2, document 39. ("Community Mutual will not recognize a discharge effected primarily for the purpose of establishing insurance coverage.").

record before the administrator this Court disagrees with the decision.

Attorney Fees, Costs and Prejudgment Interest

In an ERISA action by a participant, beneficiary or fiduciary it is within the discretion of the trial court to award reasonable attorney fees and costs to either party. 29 U.S.C. § 1132(g)(1). In considering such an award the court should consider

> 1) the degree of the opposing party's culpability or bad faith; 2) the opposing party's ability to satisfy an award of attorney fees; 3) the deterrent effect of an award on other persons under similar circumstances; 4) whether the party requesting fees sought to confer a common benefit on all participants and beneficiaries of an ERISA plan or resolve significant legal questions regarding ERISA; and 5) the relative merits of the parties' positions.

Armistead v. Vernitron Corp., 944 F. 2d 1287, 1301 (6th Cir. 1991); Secretary of Dept. of Labor v. King, 775 F. 2d 666, 669 (6th Cir. 1987).

The Defendants, no doubt, could satisfy an award of attorney fees. Upon consideration of the record, however, this Court finds that the Defendants did not proceed in bad faith and that both parties advanced

meritorious positions. Additionally, subsequent changes in Ohio law mute the deterrent effect of such an award and constrain the Plaintiffs from conferring a common benefit. O.R.C. § 3923.40. An award of attorney fees and costs is not warranted.

"The general rule is that in the absence of a statutory provision the award of prejudgment interest is in the discretion of the court." Bricklayers' Pension Trust Fund v. Taiariol, 671, F. 2d 988, 990 (6th Cir. 1982). Upon consideration of the record an award of prejudgment interest is not warranted.

CONCLUSIONS OF LAW

[1] This Court has jurisdiction pursuant to the Employee Retirement Income Security Act of 1974. 29 U.S.C. § 1001 et seq. Venue lies in the Southern District of Ohio pursuant to 28 U.S.C. § 1391(b).

[2] The Plan administrator's decision is reviewed under a de novo standard based upon the record as it appeared before the administrator. Firestone Tire and Rubber Co., v. Bruch, 489 U.S. 101 (1989); Anderson v. Great West Life Assur. Co., 942 F. 2d 392 (6th Cir. 1991);

Brown v. AMPCO-Pittsburgh Corp., 876 F. 2d 546 (6th Cir. 1989); Perry v. Simplicity Engineering, 900 F. 2d 963 (6th Cir. 1991).

[3] The Tiemeyer triplets established residency and their Plan coverage began on January 15, 1988. Perry v. Simplicity Engineering, 900 F. 2d 963 (6th Cir. 1991); Ohio Revised Code § 5103.16, § 3107.13, § 3107.10.

[4] The pleadings, depositions, answers to interrogatories, and admission on file, together with the affidavits demonstrate the absence of any genuine issue of material fact. Summary judgment is hereby GRANTED to the Plaintiffs as a matter of law. Fed. R. Civ. P. 56(c); Celotex Corp. v. Catrett, 477 U.S. 317 (1986); Firestone Tire and Rubber Co., v. Bruch, 489 U.S. 101 (1989); Perry v. Simplicity Engineering, 900 F. 2d 963 (6th Cir. 1991); Ohio Revised Code § 5103.16, § 3107.13, § 3107.10.

[5] The Plaintiffs' request for attorney fees, costs and prejudgment interest is hereby DENIED. 29 U.S.C. § 1132(g)(1). Armistead v. Vernitron Corp., 944 F. 2d 1287, 1301 (6th Cir. 1991); Secretary of Dept. of Labor v.

King, 775 F. 2d 666, 669 (6th Cir. 1987); Bricklayers' Pension Trust Fund v. Taiariol, 671 F. 2d 988, 990 (6th Cir. 1982).

IT IS SO ORDERED.

/s/
Carl S. Rubin
United States District Judge

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO

DONNA TIEMEYER, et al.

JUDGMENT
IN A CIVIL CASE

v.

Case No. C-1-90-509

COMMUNITY MUTUAL INSURANCE COMPANY, et al.

Decision by Court. This action came to trial or hearing before the Court. The issues have been tried or heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED that summary judgment is granted to plaintiffs. Plaintiff's request for attorney fees, costs and prejudgment interest is denied. CASE DISMISSED.

April 16, 1992
KENNETH J. MURPHY
Clerk

/s/
(By) Deputy Clerk

RECOMMENDED FOR FULL-TEXT PUBLICATION
Pursuant to Sixth Circuit Rule 24

Nos. 92-3415/3528/3529

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

DONNA TIEMEYER; THOMAS TIEMEYER; GEOFFREY TIEMEYER, by Donna Tiemeyer, his mother and next friend; ZACHARY TIEMEYER, by Donna Tiemeyer, his mother and next friend; JOSHUA TIEMEYER, by Donna Tiemeyer, his mother and next friend,

Plaintiffs-Appellants (92-3415), Cross-Appellees,

v.

COMMUNITY MUTUAL INSURANCE COMPANY (92-3528); CHILDREN'S HOSPITAL MEDICAL CENTER; THE CHILDREN'S HOSPITAL MEDICAL CENTER BLUE CROSS, BLUE SHIELD, AND MAJOR MEDICAL PLAN FOR REGULAR FULL-TIME AND PART-TIME EMPLOYEES (92-3529),

Defendants-Appellees. Cross-Appellants.

ON APPEAL from the United States District Court for the Southern District of Ohio

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Decided and Filed November 3, 1993

Before: KEITH and KENNEDY, Circuit Judges; and CONTIE, Senior Circuit Judge.

CONTIE, Senior Circuit Judge, delivered the opinion of the court, in which KEITH, Circuit Judge, joined. KENNEDY, Circuit Judge (pp. 21-23), delivered a separate concurring opinion.

I.

CONTIE, Senior Circuit Judge. Plaintiff-appellant cross-appellee Donna Tiemeyer ("Tiemeyer") was an employee of defendant-appellee cross-appellant Children's Hospital Medical Center ("Children's Hospital") on October 13, 1987, when she learned of the possibility of a private adoption of triplets yet to be born. She and her husband immediately contacted an attorney to represent them in securing the children. That same day, Tiemeyer contacted the benefits department at the Children's Hospital to determine the children's eligibility under "The Children's Hospital Medical Center Blue Cross, Blue Shield, and Major Medical Plan for Regular Full-Time and Part-Time Employees" (the "Plan").

On December 29, 1987, the male triplets were born at University Hospital in Cincinnati. The boys were two months premature, severely underweight and underdeveloped, and quite ill. Immediately after birth, the children were placed in the critical care unit of University Hospital. Because of their varying weights at birth (ranging from 1 lb. 15 oz., to 2 lbs. 12 oz.) and differing medical problems, the boys progressed at varying rates. Plaintiff-appellant cross-appellee Geoffrey Tiemeyer was discharged from Children's Hospital on

EDITOR'S NOTE

THE FOLLOWING PAGES WERE POOR HARD COPY AT THE TIME OF FILMING. IF AND WHEN A BETTER COPY CAN BE OBTAINED, A NEW FICHE WILL BE ISSUED.

March 2, 1988. Plaintiff-appellant cross-appellee Joshua Tiemeyer was discharged on April 23, 1988. Plaintiff-appellant cross-appellee Zachary Tiemeyer was discharged on May 13, 1988.

On December 31, 1987, two days after the triplets were born, the Tiemeyers' attorney filed a preplacement application in the Hamilton County Court of Common Pleas, Probate Division. A report on the proposed placement, completed by the Children's Protective Service, was sent to the court on January 4, 1988.

On January 15, 1988, the triplets' biological mother filed an Application for Approval of Placement. That same day, the Tiemeyers filed their Petition for Adoption. On the basis of such filings, an Entry Approving Placement was signed and journalized on January 15, 1988, by the Probate Court referee.

Tiemeyer applied for dependent coverage under the Plan for the triplets effective as of the date of their placement, January 15, 1988. Defendant-appellee cross-appellant Community Mutual Insurance Company ("Community Mutual"), the Plan's administrator, denied the Tiemeyers' application because it considered the children's "adoption date" to be the date that the children "established residence" with the policyholder. Because the children were not physically removed from the hospital prior to January 15, 1988, Community Mutual concluded that the children had not established residency with the Tiemeyers.

On April 11, 1988, the Hamilton County Probate Court conducted a hearing on the Tiemeyers' Petition for Adoption and granted an Interlocutory Order of Adoption. On November 3, 1988, the Hamilton County Probate Court entered its Final Decree of Adoption.

Tiemeyer continued to appeal Community Mutual's decision through a series of denials. Meanwhile, University Hospital filed suit against the Tiemeyers in the

Hamilton County Court of Common Pleas on December 15, 1989, seeking $289,108.99 plus interest and court costs, for nonpayment of hospital and related medical expenses incurred prior to the children's discharge dates.

Plaintiffs-appellants cross-appellees Donna, Thomas, Geoffrey, Zachary and Joshua Tiemeyer (collectively the "appellants" or "Tiemeyers") initiated this action against Community Mutual and the Children's Hospital on July 6, 1990, alleging breach of contract, violation of the Tiemeyers' civil rights, and a claim pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, Title I of which covers any employee benefit plan maintained "by any employer engaged in commerce or in any industry or activity affecting commerce" unless expressly exempted. 29 U.S.C. § 1003(a)(1). Pursuant to 29 U.S.C. § 1132(a)(1)(B), a participant or beneficiary may bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(g)(1) authorizes the court to "allow a reasonable attorney's fee and costs of action to either party."

On February 12, 1991, the Tiemeyers amended their complaint to include the Plan as a defendant. On March 6, 1991, Community Mutual, the Children's Hospital, and the Plan moved to strike counts one (breach of contract) and three (violation of civil rights) of the Tiemeyers' First Amended Complaint. On April 23, 1991, the district court granted the motion, leaving only the ERISA cause of action. On October 28, 1991, all parties filed simultaneous motions for summary judgment and a Stipulated Statement of Facts.

On April 16, 1992, the district court granted summary judgment to the Tiemeyers and ordered the payment of benefits, but denied the Tiemeyers' request for attorney fees, costs and prejudgment interest:

Community Mutual's decision to deny benefits is based upon the Tiemeyer infants' inability to satisfy an adoption date residency requirement. This requirement consists of a dependent status and a physical presence in the Tiemeyer home:

> Inasmuch as all three children have been inpatients at Children's since birth and are not primarily dependent upon her for support, it is impossible for them to have established residence with Ms. Tiemeyer prior to the date Ms. Tiemeyer's Petition for Adoption was filed, and such impossibility will continue for as long as the children remain hospitalized.

The Community Mutual Appeals Committee upheld this denial on the same ground. Upon a review of the record before the administrator this Court disagrees with the decision to deny benefit coverage.

On January 15, 1988, the natural mother consented to give the triplets up for adoption and the Tiemeyers filed the Petition for Adoption. On this date, in accordance with the Ohio Revised Code, the Tiemeyers assumed the responsibility for paying the physician and hospital expenses incurred in connection with the birth of the triplets, physician expenses incurred in connection with prenatal care or confinement, and agency expenses incurred in connection with the adoption. As of January 15, 1988, the triplets were primarily, if not totally, dependent upon the Tiemeyers for support.

Under the Plan a participant's unmarried dependent child between 19 and 25 years old, unmarried dependent child who is a full-time student, or dependent disabled child may gain coverage by satisfying a residency requirement. In

> each of these situations residency is not interpreted as requiring a physical presence in the Plan participant's home. The Defendants contend that this interpretation is justified because there is "a valid distinction to be made in that at one time [these classes of dependent children] actually lived at the subscribers' home prior to leaving."
>
> The Defendants' contention that the triplets established residency on their respective hospital discharge dates also conflicts with Ohio law. . . .
>
> In order to issue the November 3, 1988, Final Decree of Adoption as to all of the triplets the Probate Division considered January 15, 1988, as the date residency was established. If the Probate Division had construed the discharge dates as establishing residency then Zachary could not have "lived in the adoptive home for at least six months" [as required by Ohio Rev. Code] § 3107.13. The Tiemeyer triplets established residency on January 15, 1988.
>
> The administrator's decision to deny benefit coverage is an inconsistent and unreasonable interpretation under the Plan. Upon review of the record before the administrator this Court disagrees with the decision.

District Court's April 16, 1992 Order at 8-12 (citations and footnotes omitted) (brackets in original).

With respect to the Tiemeyers' claim for attorney fees, costs and prejudgment interest, the district court held:

> In an ERISA action by a participant, beneficiary or fiduciary it is within the discretion of the trial court to award reasonable attorney fees and costs to either party. 29 U.S.C. § 1132(g)(1). In considering such an award the court should consider

> (1) the degree of the opposing party's culpability or bad faith; (2) the opposing party's ability to satisfy an award of attorney fees; (3) the deterrent effect of an award on other persons under similar circumstances; (4) whether the party requesting fees sought to confer a common benefit on all participants and beneficiaries of an ERISA plan or resolve significant legal questions regarding ERISA; and (5) the relative merits of the parties' positions.
>
> The Defendants, no doubt, could satisfy an award of attorney fees. Upon consideration of the record, however, this Court finds that the Defendants did not proceed in bad faith and that both parties advanced meritorious positions. Additionally, subsequent changes in Ohio law mute the deterrent effect of such an award and constrain the Plaintiffs from conferring a common benefit. Ohio Rev. Code § 3923.40. An award of attorney fees and costs is not warranted.
>
> "The general rule is that in the absence of a statutory provision the award of prejudgment interest is in the discretion of the court." Upon consideration of the record an award of prejudgment interest is not warranted.

District Court's April 16, 1992 Order at 12-13 (citations omitted).

The Tiemeyers timely filed their Notice of Appeal on April 24, 1992 "from the final judgment denying Plaintiffs' request for attorney fees, costs and prejudgment interest entered in this action on the 16th day of April, 1992." Plaintiffs' Notice of Appeal at 1.

Defendants-appellees cross-appellants Community Mutual, the Children's Hospital, and the Plan timely filed their Notices of Appeal on May 6, 1992, appealing only

that portion of the order granting plaintiffs' motion for summary judgment.

II.

Standard of Review

Summary judgment is appropriate where "there is no genuine issue as to any material fact and . . . the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). A district court's grant of summary judgment is reviewed *de novo*. *Pinney Dock & Transp. Co. v. Penn Cent. Corp.*, 838 F.2d 1445, 1472 (6th Cir.), *cert. denied*, 488 U.S. 880 (1988). In its review, this court must view the facts and all inferences drawn therefrom in the light most favorable to the nonmoving party. *60 Ivy St. Corp. v. Alexander*, 822 F.2d 1432, 1435 (6th Cir. 1987).

The moving party has the burden of conclusively showing that no genuine issue of material fact exists. *Id.* Nevertheless, in the face of a summary judgment motion, the nonmoving party cannot rest on its pleadings but must come forward with some probative evidence to support its claim. *Celotex Corp. v. Catrett*, 477 U.S. 317, 324 (1986).

"By its very terms, this standard provides that the mere existence of *some* alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment; the requirement is that there be no *genuine* issue of *material* fact." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986) (emphasis in original). The dispute must be genuine and the facts must be such that if they were proven at trial, a reasonable jury could return a verdict for the nonmoving party. *60 Ivy St. Corp.*, 822 F.2d at 1435. If the disputed evidence "is merely colorable or is not significantly probative, summary judgment may be granted." *Anderson*, 477 U.S. at 249-50 (citations omitted).

District Court's De Novo Review

The district court applied a *de novo* standard when it reviewed the Plan Administrator's decision to deny coverage to the Tiemeyer boys:

> Under ERISA, 29 U.S.C. § 1132(a)(1)(B), a plan administrator's benefit determination is "reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). Where the administrator or fiduciary has a clear grant of discretionary authority an arbitrary and capricious standard of review applies. *Firestone*, 489 U.S. at 115. . . .
>
> . . . .
>
> The Defendants contend that Community Mutual possesses a grant of discretionary authority because a provision on the "inside cover of the [Summary Plan Description booklet] gives the plan the right and obligation to approve applicants for participation."
>
> . . . .
>
> The Defendants also contend that [a] Summary Plan Description booklet provision reserves discretion "to allow the Administrator to make determinations concerning coverage."
>
> The latter Summary Plan Description booklet provision grants discretion only as to what types of hospital care or treatment are covered. Neither provision grants Community Mutual or Children's Hospital discretionary authority to determine benefit eligibility or to construe the terms of the

> Plan. The absence of a clear grant of discretion dictates that a *de novo* standard of review applies.

District Court's April 16, 1992 Order at 6-8 (citations omitted).

The defendants-appellees cross-appellants argue (in their cross-appeal) that "[t]he District Court's literal application of [*Firestone*] does not comport with clarifying decisions of this Court." Appellees' Brief at 14. We disagree.

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the Supreme Court held that "a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* at 115. Significantly, the Supreme Court rejected Firestone's claim that the interpretation of the terms of a plan is an inherently discretionary function automatically entitling it to deferential judicial review. *See generally Wells v. United States Steel & Carnegie Pension Fund, Inc.*, 950 F.2d 1244, 1247 (6th Cir. 1991) ("[W]here a plan gives an administrator discretion to interpret the plan, the arbitrary and capricious standard still applies."); *Anderson v. Great West Life Assurance Co.*, 942 F.2d 392, 395 (6th Cir. 1991) ("[A]bsent a clear grant of discretion, the court should have reviewed Anderson's claim *de novo*."); *Callahan v. Rouge Steel Co.*, 941 F.2d 456, 459 (6th Cir. 1991) (language giving plan administrator final authority to interpret policy confers discretion sufficient to trigger deferential review); *Baker v. United Mine Workers of Am. Health & Retirement Funds*, 929 F.2d 1140, 1144 (6th Cir. 1991) (employing deferential review where plan granted trustee discretionary authority to determine issues concerning eligibility for benefits).

The defendants cite to phrases within the Plan that, they believe, grant discretionary authority to the Plan Administrator. The phrases cited use the terms "approved

by the Plan," "covered persons," and "coverage" in a number of clauses defining insurance eligibility. The defendants, in effect, maintain that the right to make coverage determinations presupposes discretionary authority. *See, e.g.*, Appellees' Brief at 15 ("In other words, some person or body within the Plan's management obviously has the obligation and discretion to determine whether the eligibility requirements have been met under the Plan's various provisions -- including the provision relating to adopted children. Moveover, by necessity, there must be some entity that determines questions of coverage. Unless that entity has the discretion to do so, the 'approval' provision is rendered superfluous.").

Because it is a legal question whether an insurance plan grants discretionary authority to a plan administrator, we must analyze the defendants' claim *de novo*. Though the instant Plan provides Community Mutual with the right to *decide* coverage questions, the Plan does not grant *discretionary authority* to Community Mutual. Because the district court properly determined that the Plan does not confer discretionary authority upon Community Mutual to determine coverage and benefit eligibility, we conclude that the district court properly applied a *de novo* standard of review when reviewing the Plan Administrator's decision to deny coverage to the Tiemeyer children.

Insurance Coverage

The terms of the Plan are set forth in a Booklet prepared by Community Mutual and distributed to Donna Tiemeyer and other Plan participants. The Booklet provides:

> This booklet is issued according to the terms of the group contract. It describes the health care benefits available to you as part of that group contract.

. . . .

We agree to provide the benefits described in this booklet.

None of our agents or employees can legally change this booklet or waive any of its provisions. Any change must be approved by one of our executive officers. This approval must be in a rider, endorsement, or amendment, which becomes a part of the group contract.

. . . .

Who is eligible

You may enroll for either individual or family coverage. Individual covers you, the employee, only; family covers you and your eligible dependents. Your spouse and certain children are eligible dependents.

Eligible children are your unmarried children who have not reached age 19. Unmarried children between the ages of 19 and 25 are eligible if they reside with you and are your dependents according to Internal Revenue Service rules. Also eligible are children of any age who are disabled by mental retardation or physical handicap before their 25th birthday. To extend eligibility to any age for these disabled children, you must furnish satisfactory proof of that dependency and disability to us within 31 days after the child's 25th birthday.

Certain other unmarried children may also be eligible. However, those children are eligible only if they live with you and are dependent upon you. They include nieces, nephews, grandchildren, and children for whom you or your spouse are the legal guardian.

Health Care Benefit Program for the Employees of Children's Hospital Medical Center ("Booklet"). The Booklet, in turn, references an underlying instrument, the Group Master Contract between Community Mutual and Children's Hospital, which is silent regarding the issues now before us.

Though the Group Master Contract and the Booklet appear unambiguous, Community Mutual referred to an Administrative Manual to determine that the Tiemeyer triplets were not eligible for benefits. This Manual, apparently created by Community Mutual to assist its claim personnel in answering questions about the Plan, consists of internal guidelines which provide (in relevant part):

> **[A]n employee adds a dependent.**
>
> . . . .
>
> In the case of child adoption, if the application is received:
>
> * within 30 days of the adoption, the adoption date becomes effective date of the coverage. The adoption date is the date the child establishes residence with the subscriber or the date the petition for adoption is filed, whichever occurs last.
>
> * within 31 to 90 days of the adoption, the coverage becomes effective upon receipt of the application.
>
> * more than 90 days after the adoption, the coverage change becomes effective during your group's annual/special reopening.

Joint Appendix at 235.

According to this provision, the dependent is covered after establishing residency with the subscriber. Pursuant to the Manual, "residency" is a requirement in four instances: (1) adopted children; (2) children between the ages of 19 and 25 ("Unmarried children between the ages of 19 and 25 are eligible if they reside with you and are your dependents according to I.R.S. rules."); (3) full-time students ("Unmarried dependent children who are full-time students and continue to reside with the contract holder are covered until the end of the year in which they reach the limiting age on your group's Master Contract."); and, (4) handicapped children (handicapped children covered unless "no longer resid[ing] with the contract holder").

A closer examination of the Administrative Manual reveals that the term residency implies legal residency, *not* physical presence. *See, e.g.*, Manual at 17 ("If your group has coverage for unmarried dependent children beyond age 19[,] coverage continues on the family contract as long as the child is dependent, has legal residence with the contractholder and is unmarried."). Moreover, the Children's Hospital's benefits administrator admitted that college students that attend college in another city, state or country would be deemed legal residents and would be covered, as would disabled children who are required to be institutionalized, even if they were never brought home from the hospital under the strained reasoning that an "unborn child is already in residence with its mother *in utero*." Appellees' Brief at 22. Because the Plan uses the terms "residence" and "established residence" in instances which are commonly known to participants to mean legal residence, we see little reason to believe that the meaning would change with regard to adopted children. *See generally Egert v. Connecticut Gen. Life Ins. Co.*, 900 F.2d 1032, 1036 (7th Cir. 1990) ("We have held that firms like Connecticut General cannot adopt *any* guidelines they choose and then rely upon these guidelines with impunity; rather, they may rely only upon those guidelines that reasonably interpret their plans.") (emphasis in original); *Reilly v.*

Blue Cross & Blue Shield of Wisconsin, 846 F.2d 416 (7th Cir.) (an insurance plan may not grant complete discretion to an internal advisory committee to pick and choose which claims will be reimbursed), *cert. denied*, 488 U.S. 856 (1988). Tiemeyer reasonably believed, pursuant to the Plan's express wording and the reasonable inferences that may be drawn therefrom, that residency would have been established when the boys were placed in her custody and she was responsible for their care.

Community Mutual explained its decision in a letter to Tiemeyer which noted: "Inasmuch as all three children have been inpatients at Children's since birth and are not primarily dependent upon her for support, it is impossible for them to have established residence with Ms. Tiemeyer." We do not agree with the appellees' claim. The children were given up by their natural mother, were not wards of the state, and were not dependents of the hospital. As the Tiemeyers noted in their Reply Brief: "Indeed, if the children had *not* been dependent on the Tiemeyers for support during the period of time between January 15, 1988 and their release from the hospital, there would be no issue for this Court to consider! University Hospital would not have filed suit against the Tiemeyers for the costs incurred in saving the children from death or disability as a result of birth related deficiencies." Appellants' Reply Brief at 12-13. Ohio law dictates that the Tiemeyers, as custodial parents of the triplets, are legally responsible for the boys' health care costs from the date of the adoption petition, January 15, 1988. Though the appellees maintain that the district court misinterpreted the relevant Ohio statutes regarding adoption, the appellees' claim is wholly unavailing.

The Group Master Contract between Community Mutual and Children's Hospital does not address the specific issue that we must resolve regarding an adopted child's right to medical coverage. The Booklet simply notes that "[w]e agree to provide the benefits described in this booklet," and concludes that "[e]ligible children are your unmarried children who have not reached age 19."

Only Community Mutual's Administrative Manual limits an adopted child's right to medical coverage. Even under the Manual's provisions, however, the district court properly determined that the Tiemeyers met the Plan's eligibility requirements. We therefore affirm the district court's medical coverage determination.

Attorney Fees and Costs

On appeal, the Tiemeyers assert that "[t]he district court abused its discretion by denying attorneys' fees in contravention of the mandates of this court and applicable federal common law." Appellants' Brief at 7.

The relevant statute provides:

> In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

29 U.S.C. § 1132(g)(1). When exercising its discretion, a trial court should consider the following factors:

> (1) the degree of the opposing party's culpability or bad faith; (2) the opposing party's ability to satisfy an award of attorney's fees; (3) the deterrent effect of an award on other persons under similar circumstances; (4) whether the party requesting fees sought to confer a common benefit on all participants and beneficiaries of an ERISA plan or resolve significant legal questions regarding ERISA; and (5) the relative merits of the parties' positions.

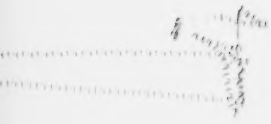
Secretary of Dep't of Labor v. King, 775 F.2d 666, 669 (6th Cir. 1985) (adopting the analysis advanced by the Tenth Circuit in *Eaves v. Penn*, 587 F.2d 453 (10th Cir. 1978)). Later courts have expounded on 29 U.S.C. § 1132(g)(1) and the five-factor *King* analysis:

> We believe that the broad wording of the statute has the effect of repealing the American Rule in ERISA cases and permitting the federal courts to devise a common law of fee-shifting. In doing so, the courts may take into consideration any of the legitimate, relevant purposes for which fee-shifting has been permitted or proposed, including punishing bad faith litigants, providing the plaintiff with complete relief in appropriate cases, preventing the unjust enrichments of those who benefit from successful litigation, or removing deterrents to meritorious litigation by reducing the disparity between the resources available to the parties. The *King-Eaves* factors, which include many of the traditional reasons for awarding fees, are as good a place as any to begin the development of a common law of fee-shifting under ERISA, even if they do not turn out to be the final word on the subject.

Armistead v. Vernitron Corp., 944 F.2d 1287, 1303-04 (6th Cir. 1991). We review the denial of attorney fees under 29 U.S.C. § 1132(g)(1) for an abuse of discretion. *Sweet v. Consolidated Aluminum Corp.*, 913 F.2d 268, 271 (6th Cir. 1990).

Much of the Tiemeyers' argument regarding the award of attorney fees speaks merely to the "equities" involved. *See, e.g.*, Appellants' Brief at 14 ("Unfortunately, if the district court's decision is affirmed, bankruptcy is inevitable, notwithstanding the favorable decision on the merits. How ironic that the legal system, under these circumstances, can provide a substantial recovery for Plaintiffs' creditors, but so insubstantial a recovery to Plaintiffs as to leave them overburdened with legal fees and interest charges, the extent of which puts them in the same insolvent condition as if they did nothing in the first place to contest the issue of medical coverage.").

The district court's order reveals that the court carefully examined the facts presented by both sides and determined



that the defendants-appellees acted in good faith. Though the district court determined that Community Mutual and Children's Hospital have the financial ability to pay reasonable attorney fees, the district court determined that: subsequent changes in Ohio statutory law obviated the need for a deterrent effect; the revised Ohio statute precluded a common benefit to individuals seeking to adopt children under similar circumstances; and, all parties presented meritorious positions.

Because the Tiemeyers failed to demonstrate that the district court abused its discretion by denying the plaintiffs-appellants' request for attorney fees, we affirm the district court's attorney fee determination. *See generally Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550, 557-58 (6th Cir. 1987) ("Finally, we conclude that consideration of the parties' relative ability to pay does not justify an award of fees. Although Firestone clearly possesses the ability to pay, this factor alone should not be dispositive when examination of all other relevant factors indicates that fees should not be awarded.").

Prejudgment Interest

On appeal, the Tiemeyers argue that "[i]t is manifest that the district court acted counter to the remedial purpose of ERISA in denying prejudgment interest in this case." Appellants' Brief at 22. Though ERISA does not address the propriety of awarding prejudgment interest, prejudgment interest may be awarded in the discretion of the district court. *Bricklayers' Pension Trust Fund v. Taiariol*, 671 F.2d 988, 990 (6th Cir. 1982). "Awards of prejudgment interest are compensatory, not punitive, and a finding of wrongdoing by the defendant is not a prerequisite to such an award." *Drennan v. General Motors Corp.*, 977 F.2d 246, 253 (6th Cir. 1992), *cert. denied*, 113 S. Ct. 2416 (1993).

The district court, with little explanation, refused to impose prejudgment interest noting only: "Upon

consideration of the record an award of prejudgment interest is not warranted." District Court's April 16, 1992 Order at 13.

In *Sweet v. Consolidated Aluminum Corp.*, this court noted:

> Even assuming arguendo that the Trustee was acting prudently in withholding the pension funds until December of 1985, it cannot be said that this did not confer a benefit on the trustee. Any additional time one gains, rightfully or wrongfully, in not having to submit payment of a sum of money owed another is without doubt a benefit. Moreover, the payee, plaintiff-appellant herein, has been deprived of the benefit of those payments. . . . "To allow the Fund to retain the interest it earned on funds wrongfully withheld from a beneficiary would be to approve of an unjust enrichment. Further, the relief granted would fall short of making the beneficiary whole because he has been denied the use of money which was his."

913 F.2d at 270 (citation omitted). *See also Rivera v. Benefit Trust Life Ins. Co.*, 921 F.2d 692, 697 (7th Cir. 1991) ("The ability of defendants to earn interest on funds which should have been expended to pay plaintiffs' medical benefits under the policy would result in the unjust enrichment of defendants. Relieving defendants from the payment of prejudgment interest would create an incentive for insurers to delay payment and would undercompensate victims by forcing them to absorb expenses incurred as a result of the delay.").

Because the appellees benefitted from their inaction as the Tiemeyers' debt compounded each year that it remained unpaid, we find that the district court abused its discretion by denying the Tiemeyers' request for prejudgment interest without explanation. Accordingly, we remand the prejudgment interest issue to the district

court with instructions to the court to support its determination with factual findings. *See Drennan v. General Motors Corp.*, 977 F.2d at 253 ("Because an award of prejudgment interest is compensatory rather than punitive, the district court should have considered the position of the Class rather than the conduct of GM in arriving at a resolution of this issue. Thus, the denial of prejudgment interest on the damages award is remanded with instructions to support an award or denial of prejudgment interest with findings of fact incorporating its reasons for its decision.").

III.

We AFFIRM the district court's April 16, 1992 order in all respects except for the prejudgment interest claim which we REMAND to the district court for factual findings to support the district court's decision.

KENNEDY, Circuit Judge, concurring.

Whether the administrator of this Plan has discretionary authority to construe the terms of the Plan and determine eligibility is a close question here. This discretionary authority is purportedly derived from the Summary Plan Description:

> Subject to the payment of fees, all persons who have
>
> * satisfied the eligibility conditions,
>
> * applied for coverage, and
>
> * have been approved by the Plan
>
> are covered by the group contract. Such persons are called covered persons.

I believe that the requirement that covered persons be "approved by the Plan" must have some meaning.

The majority recognizes that the instant Plan permits Community Mutual the right to *decide* coverage questions, but holds that that right to decide does not include the grant of discretionary authority. I cannot agree. When the Plan fiduciary has reserved the right to decide coverage issues, it seems to me that is a reservation of fiduciary discretionary authority. Indeed, it is the administrator's discretionary authority to interpret the Plan that created plaintiffs' claim to hospital costs for the children here: The claim is not based upon language of the Plan, rather, it is based upon language found in the Administrative Manual, which contains the administrator's interpretation of the Plan in accordance with what it believed to be its discretionary authority reserved to it

under the Plan.[1] The Plan only provides for medical and hospital costs for certain children of the employee. I do not think it is argued that under the Plan, these children became "children of the employee" until the adoption was completed. If they are to be covered from the time the petition for adoption is filed until the adoption occurs, it must be because of the provisions of the Manual. The Manual provides coverage for adopted children as soon as the petition for adoption is filed and residence is with the adopting parent, even though the adoption process is not yet complete.

I concur, however, in the majority opinion because I believe that the Plan acted arbitrarily when it concluded that the children here did not reside with the adopting parents after the Ohio Probate Court issued its order acknowledging the placement and petition for adoption. That order placed the children with the adopting parents. The children had to have a residence somewhere. Children ordinarily have the residence of their parents. Here, the legal right to have the children at their residence had been transferred to the adopting parents. These children no longer had the residence of their birth mother. The children would have gone home with the adopting parents at that time except for their fragile condition. It was the intent of the birth mother and the adopting parents that the children's residence be transferred to the adopting parents and the State of Ohio had approved of that transfer of residence. Since infants are unable to have intent, we must look to the intent of those adults who have their care. There was no intent on the part of the birth mother, the adopting parents or the state that the children reside at the hospital. Their continued presence in the hospital was a mere fortuitous result of their low birth weights. The residence requirement was intended to avoid the situation where a child would continue to remain with the birth parent(s) while the adoption was proceeding or where

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[1] As the majority points out, the Manual was apparently created to "assist claim personnel" and "consists of internal guidelines."

someone might adopt a child in order to provide the child with health care and the child might never reside with the adopting parents. It seems to me arbitrary and capricious under the facts of this case to find, as the administrator of the Plan did, that the children did not reside with the adopting parents until they were taken home from the hospital. Thus, I concur in the result reached by the majority and would also AFFIRM.